W-0001-001

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Printed: 12/29/2016 FORM APPROVED OMB NO, 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

495141

8. WING

12/27/2016

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

1725 MAIN STREET CLIFTON FORGE, VA 24422

| Name and Publishers of Street | | MAI ONGE, | , VA 24422 | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | Surveyor: 21761 Construction Type: II(000) Number of stories: One Story Building description: The facility is a one-story building of unprotected, noncombustible construction with concrete floors. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted 12/27/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. | K 000 | Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. K 293 1.) Address the corrective action taken for the identified problem. The exit signs were ordered on 12/29/16 to be delivered on 01/04/17 and to be installed on 01/08/17. 2.) Address how facility will identify similar occurrences of the problem. No similar occurrences were identified upon facility rounds on 01/03/17. 3.) Identify measures/systemic changes to ensure deficient practice will not recur. | |
| K 293 SS=F | The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.) NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies | K 293 | The Maintenance Director and or Maintenance Assistant have added checking the courtyard exit signs to their Maintenance rounds checklist. 4.) Indicate how facility will monitor its performance. The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklist, along with work order history with the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. | |
| 1 | | | of rate of collection. | 1 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

HILL

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

duculations

3 p.m.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016 **FORM APPROVED** OMB NO. 0938-0391

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| K 300 SS=F | Continued From page 1 with less than 30 occupants where the line travel is obvious.) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide exit significanced as follows; Findings include: On 12/27/16, at approximately 11:42 A.M., observed there are no exit signs provided if the enclosed courtyard back into the building. The Maintenance Director witnessed this evidence by observation and interview. NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section and 19.3 Protection requirements that not addressed by the provided K-tags, but deficient. This information, along with the applicable Life Safety Code or NFPA standictation, should be included on Form CMS- This Standard is not met as evidenced by Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doo evidenced as follows; Findings include: On 12/27/16 upon records review, at approximately 11:42 A.M., it was observed documentation could not be provided for rate and the surveyor of the provided for rate and the provided for provided for provided for provided for prate and the provided for provided for provided for provided for p | it was from ng. K 300 ction t are are lard -2567. | 1.) Address the corrective action taken for the identified problem. The Facility Maintenance Director and Maintenance Assistant completed rated door testing and inspection on 01/06/17. 2.) Address how facility will identify similar occurrences of the problem. No similar occurrences were identified on rated door testing and inspection on 01/06/17. 3.) Identify measures/systemic changes to ensure deficient practice will not recur. The Maintenance Director and or Maintenance Assistant will test and inspect rated doors monthly and document findings for compliance. 4.) Indicate how facility will monitor its performance. The documented findings and inspection of the rated doors will be submitted and discussed in the safety committee monthly and any Issues will be submitted to the QAPI committee at least quarterly for additional recommendations. 5.) Date of correction. Compliance Date is 01/19/17 | |
| | 2567(02-99) Previous Versions Obsolete | 2104 | RDSY24 If continuation a | hant Dans O - 110 |

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| K 300 | Continued From page 2 door testing and inspection. (Sections 7.2.1.15.2, 7.2.1.15.3, 7.2.1.15.4) | K 300 | K 711 1.) Address the corrective action taken | - |
| K 711 | The Maintenance Director witnessed this evidence by observation and interview. | | for the identified problem. The written emergency procedures as of 01/05/17 do include the removal of wheeled equipment stored in corridors. | |
| SS=F | NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of | K 711 | The Facility written emergency procedure booklets/binders/manuals at the nurses stations have been updated and revised as of 01/05/17 to match the facility master procedures manual. | A CONTRACTOR CONTRACTO |
| | an emergency, Employees are periodically instructed and kept informed with their duties under the plan, and a | | Address how facility will identify similar occurrences of the problem. | |
| | copy of the plan is readily available with telephone operator or with security. The plan | OPERAL AND | No similar occurrences were identified upon review of procedures and manuals on 01/05/17. | - |
| | addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, | | 3.) identify measures/systemic changes to ensure deficient practice will not recur. | |
| | 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was | | The Director of Clinical Education will re- in service and reeducate staff on emergency procedure booklets/binders/manuals content and location. | THE RESERVE THE PROPERTY OF TH |
| · · | revealed the facility failed to provide complete emergency procedures, evidenced as follows; | | The Maintenance Director and or Maintenance Assistant will review and update the emergency procedures, Facility emergency | |
| | Findings include: | | booklets/binders/manuals as necessary and required on a monthly basis. | *************************************** |
| | On 12/27/16 at approximately 12:20 P.M., it was observed during record review that the written emergency procedures do not include th | e | 4.) Indicate how facility will monitor its performance. | |
| | removal of wheeled equipment stored in corridors. | and a desiration of the second | The Maintenance Director and or Maintenance Assistant will review changes and updates to the Facility | |
| | On 12/27/16 at various times during the survey, it was observed during record review the the written emergency procedure booklets at the nurses' stations do not contain the latest revisions to match the facility's master | at e | written emergency procedures and booklets/binders/manuals with the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly for additional recommendations. | |

FORM CMS-2567(02-99) Previous Versions Obsolete

5.) Date of correction.

Compliance Date is 01/19/17

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| K 711 | Continued From page 3 | K 711 | | |
| | procedures manual. | | K 753 | |
| | The Administrator witnessed this evidence by observation and interview. | | Address the corrective action taken for the identified problem. | |
| K 753 SS=F | NFPA 101 Combustible Decorations | K 753 | The decorative holiday cardboard fireplace was removed from the main lobby on 12/27/16 by facility staff, | t de la constant de l |
| | Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: | | 2.) Address how facility will identify similar occurrences of the problem. | |
| | * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. | | No similar occurrences were identified during facility rounds and observation on 12/27/16. | Assemble and the second |
| | * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. | | 3.) Identify measures/systemic changes to ensure deficient practice will not recur. | |
| | * Decorations, such as photographs, paintings and other art are attached to the walls, cellings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in | | Current staff will be re-educated and re-in serviced on combustible holiday decorations by the Director of Clinical Education. The resident council will be re informed of regulation requirements. | |
| | such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 This Standard is not met as evidenced by: | | The Maintenance Director and or Maintenance Assistant will add combustible decorations to the Maintenance round checklists. | |
| | Surveyor: 21761 Based on observation and interview, it was revealed the facility falled to comply with the | | 4.) Indicate how facility will monitor its performance. | |
| | requirements for combustible decorations. | | The Maintenance Director and or Maintenance Assistant will review the | |
| | Findings include: | , | Maintenance rounds checklist pertaining to combustible decorations at the safety committee meeting with those minutes | |
| | On 12/27/16, at approximately 12:35 P.M., it was observed that there is a large combustible cardboard fireplace in the main lobby. | | forwarded to QAPI at least quarterly for trending and tracking as well as additional recommendations for compliance if required. | |
| | The Maintenance Director witnessed this evidence by observation and interview. | | 5.) Date of correction. | |
| K 901 SS=F | NFPA 101 Fundamentals - Building System | K 901 | Compliance Date is 01/19/17 | |
| ODM CMC | 2567(02-99) Provious Varaines Charleto | 1 | | |

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| K 901 | Continued From page 4 | K 901 | K 901 | 1 |
| | Fundamentals - Building System Categories Building systems are designed to meet Categories | jory | Address the corrective action taken for the identified problem. | Villago of the Control of the Contro |
| 7.00 | 1 through 4 requirements as detailed in NFPA Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. | \ 99. | A category risk assessment was documented and completed on 01/04/17 by the Administrator and Nurse Unit Managers | The state of the s |
| *************************************** | Chapter 4 (NFPA 99) | | 2.) Address how facility will identify similar occurrences of the problem. | |
| | | | No similar occurrences were identified at this time 01/04/17. | |
| THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PR | This Standard is not met as evidenced by: Surveyor: 21761 | | 3.) Identify measures/aystemic changes to ensure deficient practice will not recur. | |
| | Based on observation and interview, it was revealed the facility failed to provide a formal documented category risk assessment, evidenced as follows; | and | The Facility Administrator, Director of Nursing and or Nurse Unit Managers will complete a formal and documented category risk assessment monthly. | |
| | Findings include: | | Indicate how facility will monitor its performance. | |
| | On 12/27/16 upon records review, at approximately 12:55 P.M., it was observed the no documentation could be provided for a for and documented risk assessment. | at mal | The Facility Administrator, Director of Nursing and or Nurse Unit Managers will trend and report any issues from the monthly risk assessment to the QAP! committee for additional follow up. | |
| | The Maintenance Director witnessed this evidence by observation and interview. | | 5.) Date of correction. Compliance Date is 01/19/17 | · Maria |
| K 914 SS=F | NFPA 101 Electrical Systems - Maintenance Testing | and K 914 | | |
| | Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or genera anesthesia is administered, are tested after ir installation, replacement or servicing. Addition testing is performed at intervals defined by documented performance data. Receptacles listed as hospital-grade at these locations are | il nitial nal | | |
| RM CMS-2 | 567(02-99) Previous Versions Obsolete | | PD6Y24 If continuation o | |

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| ALLEGHANY HEALTH AND REHAB | | 1725 MAIN STREET CLIFTON FORGE, VA 24422 | | | |
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| K 914 | Continued From page 5 tested at intervals not exceeding 12 mo isolation monitors (LIM), if installed, are Intervals of less than or equal to 1 mont actuating the LIM test switch per 6.3.2.6 which activates both visual and audible For LIM circuits with automated self-tes manual test is performed at intervals les equal to 12 months. LIM circuits are tes 6.3.3.3.2 after any repair or renovation electric distribution system. Records are maintained of required tests and associ repairs or modifications, containing date area tested, and results. 6.3.4 (NFPA 99) This Standard is not met as evidenced Surveyor: 21761 Based on observation and interview, it revealed the facility failed to provide pe testing of electrical equipment, evidence follows; Findings include: | tested at h by 5.3.6, alarm. ting, this is than or ted per to the ated ated by: | K 914 | K 914 1.) Address the corrective action taken for the identified problem. The Maintenance Director and Maintenance Assistant completed inspection and testing of non-hospital grade receptacies in patient care areas on 01/04/17. 2.) Address how facility will identify similar occurrences of the problem. No similar occurrences were identified at this time by the Maintenance Director and Maintenance Assistant. 3.) Identify measures/systemic changes to ensure deficient practice will not recur. The Maintenance Director and or Maintenance Assistant will conduct inspection and testing of non-hospital grade electrical receptacies on at least an annual basis and monitor on Maintenance rounds checklists. | |
| K 915 SS=F | i i i i i i i i i i i i i i i i i i i | nentation lesting for lesting for lis lis al Electric System ch e major rooms | K 915 | 4.) Indicate how facility will monitor its performance. The Maintenance Director will document any trends and corrective action taken and report monthly to the QAPI committee for further recommendations 5.) Date of correction. Compliance Date is 01/19/17 | |

Printed: 12/29/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495141 12/27/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALLEGHANY HEALTH AND REHAB **1725 MAIN STREET CLIFTON FORGE, VA 24422** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS-DATE TAG OR LSC IDENTIFYING INFORMATION) REFERENCED TO THE APPROPRIATE TAG DEFICIENCY K 915 Continued From page 6 K 915 K 915 are served by a Type 1 EES. 1.) Address the corrective action taken *General care rooms (Category 2) in which for the identified problem. electrical system fallure is likely to cause minor Category documentation for essential injury to patients (Category 2) are served by a electrical systems was completed on Type 1 or Type 2 EES. 01/03/17. *Basic care rooms (Category 3) in which electrical system fallure is not likely to cause 2.) Address how facility will identify similar occurrences of the problem. injury to patients and rooms other than patient care rooms are not required to be served by an No similar occurrences were identified EES. Type 3 EES life safety branch has an upon completion of category alternate source of power that will be effective for documentation for essential electrical 1-1/2 hours. systems on 01/03/17. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 3.) Identify measures/systemic 99), TIA 12-3 changes to ensure deficient practice This Standard Is not met as evidenced by: will not recur. Surveyor: 21761 Category documentation for essential Based on observation and interview, it was electrical systems will be updated revealed the facility failed to provide electrical monthly by the Administrator and or systems documentation, evidenced as follows: Maintenance Director / Maintenance , #Assistant to ensure compliance Findings include: 4.) Indicate how facility will monitor its performance. On 12/27/16, upon records review, at approximately 11:57 A.M., it was observed there The Administrator and or Maintenance is no category documentation provided for Director will document any trends and esseiltial electrical systems. corrective action taken and report monthly to the QAPI committee for further recommendations The Maintenance Director witnessed this evidence by observation and interview. 5.) Date of correction. K 918 NFPA 101 Electrical Systems - Essential Electric K 918 Compliance Date is 01/19/17 SS=F Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of

supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and

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STREET ADDRESS, CITY, STATE, ZIP CODE

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| critical branches. Maintenance and test generator and transfer switches are per accordance with NFPA 110. Generator sets are Inspected weekly, exunder load 30 minutes 12 times a year in day intervals, and exercised once every months for 4 continuous hours. Schedule under load conditions include a complete simulated cold start and automatic or matransfer of all EES loads, and are conducted energy power sources (Type 3 EE accordance with NFPA 111. Main and fe circuit breakers are inspected annually, a program for periodically exercising the components is established according to manufacturer requirements. Written recommended and testing are maintained readily available. EES electrical panels a circuits are marked and readily identifiab Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, 111, 700.10 (NFPA 70) This Standard is not met as evidenced be Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide emergenerator maintenance, evidenced as follows: 1. On 12/27/16 at approximately 12:57 for was observed during record review that the precords of the generator battery electrical parters. | cliffo segulatory ling of the formed in ercised 120-40 36 ed test elected by testing of ES) are in eder and a elected by testing of and le. NFPA NFPA NFPA NFPA NFPA OFFICIENT APPRICATE TO THE PARTY IN THE P | IAIN STREDN FORGE ID PREFIX TAG K 918 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 918 1.) Address the corrective action taken for the identified problem. Maintenance completed documentation of generator battery electrolyte levels on 01/04/17. Generator monthly testing was completed on 12/28/16. Documentation was located after survey. 2.) Address how facility will identify similar occurrences were identified. 3.) Identify measures/systemic changes to ensure deficient practice will not recur. Documentation for generator battery electrolyte, generator testing will be updated and documented monthly by the Maintenance Director / Maintenance Assistant and forwarded to the Administrator for review and compliance 4.) Indicate how facility will monitor its performance. The Administrator and or Maintenance Director will document any trends and corrective action taken and report to the QAPI committee quarterly for further recommendations 5.) Date of correction. Compliance Date is 01/19/17 | COMPLETION DATE |
| no records of the generator battery electric evels. 2. On 12/27/16 at approximately 12:58 Pwas observed during record review that the | olyte | | | |

Printed: 12/29/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495141 12/27/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ALLEGHANY HEALTH AND REHAB 1725 MAIN STREET** CLIFTON FORGE, VA 24422 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES m PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS-TAG OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) K918 Continued From page 8 K 918 no records of generator monthly testing for K 919 several months. 1.) Address the corrective action taken for the identified problem. The Maintenance Director witnessed this The function box was to be installed by evidence by observation and interview. the electrician on 01/08/17, K 919 NFPA 101 Electrical Equipment - Other K 919 2.) Address how facility will identify SS=D almilar occurrences of the problem. Electrical Equipment - Other No similar occurrences were identified List in the REMARKS section any NFPA 99 upon facility rounds on 01/08/17. Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags. 3.) Identify measures/avatemic but are deficient. This information, along with the changes to ensure deficient practice will not recur. applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. The Maintenance Director and or Chapter 10 (NFPA 99) Maintenance Assistant have added This Standard is not met as evidenced by: checking the laundry junction boxes to Surveyor: 21761 their Maintenance rounds checklist. Based on observation and interview, it was 4.) Indicate how facility will monitor its revealed the facility failed to maintain electrical performance. equipment, evidenced as follows; The Maintenance Director and or Maintenance Assistant will review the Findings include: Maintenance rounds checklist, along with work order history with the safety On 12/27/16 at approximately 2:56 PM, it was committee monthly and any issues will be observed there is an electrical wiring splice that submitted to the QAPI committee at least is not protected by an approved junction box for quarterly for additional recommendations. the exhaust fan behind the clothes dryers. 5.) Date of correction. The Maintenance Director witnessed this Compilance Date is 01/19/17 evidence through observation and interview. K 920 NFPA 101 Electrical Equipment - Power Cords K 920 SS=D and Extens Electrical Equipment - Power Cords and **Extension Cords** Power strips in a patient care vicinity are only

used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL I OR LSC IDENTIFYING INFORMATION) | ** | ID PREFIX TAG | PROVIDER'S PLAN OF CO CORRECTIVE ACTION SI REFERENCED TO THE | IOULD BE CROSS- EAPPROPRIATE | COMPLETION DATE |
| K 920 | D Continued From page 9 by qualified personnel and meet the cor 10.2.3.6. Power strips in the patient car may not be used for non-PCREE (e.g., electronics), except in long-term care re rooms that do not use PCREE. Power s PCREE meet UL 1363A or UL 60601-1. strips for non-PCREE in the patient care (outside of vicinity) meet UL 1363. In no care rooms, power strips meet other UL standards. All power strips are used with precautions. Extension cords are not us substitute for fixed wiring of a structure. Extension cords used temporarily are re immediately upon completion of the pury which it was installed and meets the cor 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 4 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-This Standard is not met as evidenced is surveyor: 21761 | re vicinity personal sident trips for Power e rooms on-patient the general sed as a moved pose for ditions of 00-8 5 | K 920 | K 920 1.) Address the correct for the identified proble The multiple-outlet exten adapter in the lobby and were removed on 12/27/ 2.) Address how facility similar occurrences of No similar occurrences of upon rounds on 01/04/17 3.) Identify measures/s changes to ensure defi will not recur. The Maintenance Direct Maintenance Assistant will document weekly on the rounds checklists that ar for multiple extension co adapters. | ive action taken am. slon cords and Activities Room 16. will identify the problem. were identified v. systemic clent practice or and ill check and ir Maintenance eas are checked | DATE |
| | Based on observation and interview, it was revealed the facility failed to properly use electrical equipment, evidenced as follows: 1. On 12/27/16 at approximately 12:40 has observed by inspection that there is unapproved multiple-outlet extension compowering the Christmas tree in the entral lobby. 2. On 12/27/16 at approximately 3:05 P. was observed by inspection that there is unapproved multiple-outlet adapter in use Activities Room of A-Wing. The Maintenance Director witnessed this evidence by observation and interview. | evs; o.M., it an rd nce M., it an e in the | | 4.) Indicate how facility performance. The Maintenance Direct Maintenance Assistant will Maintenance rounds che and submit findings to the committee monthly and a submitted to the QAPI or quarterly. 5.) Date of correction. Compliance Date is 01/1 | or and or vill review the locklists monthly e safety any issues will be ommittee at least | • Sing Promotestion |
| | NFPA 101 Electrical Equipment - Testing | and | K 921 | | | |
| M CMS-2 | 567(02-99) Previous Versions Obsolete | | | RD6Y21 | // continued a | |

Printed: 12/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

495141

B. WING

12/27/2016

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE **1725 MAIN STREET**

| | | ON FORGE | VA 24422 | v v |
|---|---|--|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X6) COMPLETION DATE |
| K 921 | Continued From page 10 | K 921 | | |
| SS=F | Maintenanc | K 921 | K 921 | |
| | Electrical Equipment - Testing and Maintenance | | 1.) Address the corrective action taken for the identified problem. | |
| | Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment | the state of the s | Portable Patient Care Related Electrical Equipment will be Inspected and tested by Maintenance Director and Maintenance Assistant by 01/10/17 | |
| | (PCREE) is performed as required in 10.3. Testing intervals are established with policies and | | 2.) Address how facility will identify similar occurrences of the problem. | |
| * | protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.5 | | No similar occurrences were identified. | |
| is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance | | 3.) Identify measures/systemic changes to ensure deficient practice will not recur. | | |
| | with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical | | The Maintenance Director and Maintenance Assistant will test and inspect all portable patient care related electrical equipment weekly on their Maintenance rounds checklists. | |
| | equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and | | indicate how facility will monitor its performance. | VOID CONTRACT AND ANALOGUE AND |
| readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances | | The Maintenance Director and or Maintenance Assistant will review the Maintenance rounds checklists related to portable patient care related electrical equipment monthly and submit findings to the safety committee monthly and any issues will be submitted to the QAPI committee at least quarterly. | | |
| | receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, | | 5.) Date of correction. | |
| | 10.5.6, 10.5.8 This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide testing of | | Compliance Date is 01/19/17 | |
| | electrical equipment, evidenced as follows; | придорени пред | | |
| | Findings include: | | | The state of the s |

; p.m.

15/19

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 12/29/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495141 B. WING 12/27/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **ALLEGHANY HEALTH AND REHAB** 1725 MAIN STREET **CLIFTON FORGE, VA 24422** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX CORRECTIVE ACTION SHOULD BE CROSS-TAG OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) K 921 Continued From page 11 K 921 On 12/27/16 at approximately 11:20 A.M., It was K 923 observed during review of facility documentation 1.) Address the corrective action taken there are no records of inspection and testing for for the identified problem. portable patient care related electrical equipment. Signage was ordered on 12/28/16 and installed on the doors on 01/03/17. The Maintenance Director witnessed this evidence by observation and interview. 2.) Address how facility will identify K 923 NFPA 101 Gas Equipment - Cylinder and K 923 similar occurrences of the problem. SS=F Container Storag No similar occurrences were identified upon rounds on 01/03/17. Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet 3.) Identify measures/systemic Storage locations are designed, constructed, and changes to ensure deficient practice ventilated in accordance with 5.1.3.3.2 and will not recur. 5.1.3.3.3. The Facility Maintenance Director and or >300 but <3,000 cubic feet Maintenance Assistant will document that Storage locations are outdoors in an enclosure or the oxygen storage rooms have the within an enclosed interior space of non- or proper signage that includes the required wording on their Maintenance rounds limited- combustible construction, with door (or checklists. gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are 4.) Indicate how facility will monitor its separated from combustibles by 20 feet (5 feet if performance. sprinklered) or enclosed in a cabinet of The Maintenance Rounds checklists will noncombustible construction having a minimum be reviewed and submitted to the 1/2 hr. fire protection rating. Administrator weekly for tracking and Less than or equal to 300 cubic feet trending and results reported to the In a single smoke compartment, individual Safety Committee monthly and QAPI cylinders available for immediate use in patient committee at least quarterly for additional care areas with an aggregate volume of less than recommendations. or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be 5.) Date of correction. handled with precautions as specified in 11.6.2. Compliance Date is 01/19/17 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a

minimum "CAUTION: OXIDIZING GAS(ES)

Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full

STORED WITHIN NO SMOKING."

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016 FORM APPROVED OMB NO. 0938-0391

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| AND | PLAN | OF | CO | RR | ECT | ON |

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

495141

B. WING _

12/27/2016

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE

1725 MAIN STREET CLIFTON FORGE, VA 24422

| | | N FORGE, | VA 24422 | *. |
|--------------------------|--|---------------------|---|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (XS) COMPLETION DATE |
| K 923 | cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility falled to properly mark medical gas storage, evidenced as follows; Findings include: On 12/27/16 at various times it was observed by inspection that the oxygen storage rooms signage throughout the facility did not include the wording ""CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING", at a minimum. The Maintenance Director witnessed this evidence by observation and interview. | K 923 | | |
| | | - 1 | | |

| D | EPARTMENT | OF HEALTH AND | HUMAN SERVICES |
|---|------------|---------------|-----------------------|
| C | ENTERS FOR | MEDICARE & M | EDICAID SERVICES |

W-0001-002

Printed: 12/29/2016 FORM APPROVED OMB NO. 0938-0391

| STATEMENT | OF | DEFICIENCIES |
|------------|----|--------------|
| AND PLAN O | FC | ORRECTION |

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - PHARMACY DISPENSING
AREA

(X3) DATE SURVEY COMPLETED

495141

B. WING

12/27/2016

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET

| ALLEGHANY HEALTH AND REHAB 1725 M. CLIFTO | | | ET , VA 24422 | |
|---|--|--------|--|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION) | l in | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | INITIAL COMMENTS | K 000 | | |
| | Surveyor: 21761 Construction Type: II(000) Number of stories: One Story Bullding description: The facility is a single room within the Main one-story building of unprotected noncombustible construction with concrete floors. This room is the Pharmacy Storage room only, and does not contain sleeping areas. Sprinkler Status: The building is fully sprinklere and protected by NFPA #13 systems supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted 12/27/16 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. | d y | Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. This plan of correction is the facility's credible allegation of compliance. | |
| K 918 SS≃F | The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.) NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of | K 918 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

01/06/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PHARMACY DISPENSING AREA

(X3) DATE SURVEY COMPLETED

495141

B. WING

12/27/2016

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE **1725 MAIN STREET**

CLIFTON FORGE, VA 24422

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|--------------------------|--|---------------------|---|----------------------------|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| | Continued From page 1 supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of mainfenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily Identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations, 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This Standard is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide emergency generator maintenance, evidenced as follows; Findings include: | K 918 | 1.) Address the corrective action taken for the identified problem. Maintenance completed documentation of generator battery electrolyte levels on 01/04/17. Generator monthly testing was completed on 12/28/16. Documentation was located after survey. 2.) Address how facility will identify similar occurrences of the problem. No similar occurrences were identified. 3.) Identify measures/systemic changes to ensure deficient practice will not recur. Documentation for generator battery electrolyte, generator testing will be updated and documented monthly by the Maintenance Director / Maintenance Assistant and forwarded to the Administrator for review and compliance 4.) Indicate how facility will monitor its performance. The Administrator and or Maintenance Director will document any trends and corrective action taken and report to the QAPI committee quarterly for further recommendations 5.) Date of correction. Compliance Date is 01/19/17 | |
| | manage monder. | Į. | | |

1. On 12/27/16 at approximately 12:57 P.M., it was observed during record review that there are no records of the generator battery electrolyte

| DEPARTMENT | OF HEALTH AND HUM | AN SERVICES |
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Printed: 12/29/2016 FORM APPROVED OMB NO. 0938-0391

12/27/2016

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| AND | PLAN | OF | COR | REC | TION |

NAME OF PROVIDER OR SUPPLIER

ALLEGHANY HEALTH AND REHAB

ζ.

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - PHARMACY DISPENSING AREA

(X3) DATE SURVEY COMPLETED

495141

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

1725 MAIN STREET

| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES | N FORGE, | 7 | |
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| TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | COMPLETION DATE |
| K 918 | Continued From page 2 levels. | K 918 | | |
| | 2. On 12/27/16 upon records review, at approximately 12:58 P.M., it was observed during record review that there are no records of generator monthly testing for several months. | , professor sections and an assessment | | |
| | The Maintenance Director witnessed this evidence by observation and interview. | | | • |
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2012 LIFE SAFETY CODE Form Approved OMB Exempt

W-0001-001

| FIRE SAFETY SURVEY REPORT 2012 CODE Medicare – Medicaid | VEY REPORT 2012 CO Medicare – Medicaid | r 2012 CODE Medicaid | : - HEALTH CARE | | 1. (A) PROVIDER NUMBER 49-5141 | 1. (B) MEDICAID I.D. NO. 49-51417 | OZ. |
|--|--|---|--|--|---|---|--|
| TdO | IONAL — Chapt | PAR: | PART I — Life Safety Code, New and Existing PART II — Health Care Facilities Code, New and Existing PART III — Recommendation for Waiver PART IV – Crucial Data Extract A 101A - Fire Safety Evaluation System for Health Care O | Code, New ilities Code, mendation ricial Data Extern System | ccupano | ks cies – CMS-2786T | |
| Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change. | own in applicable | records. Enter | changes, if any, alongs | ide each ite | m, giving date of change. | | |
| 2. NAME OF FACILITY Alleghany Health & Rehab Main Bldg. | | 2. (A) MULTIPLE CONST A. BUILDING B. WING C. FLOOR | RUCTION (BLDGS) | (B) ADDRESS OF FACILI 1725 Main Street Clifton Forge, VA | 2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 1725 Main Street Clifton Forge, VA 24422 | TATE, ZIP CODE) A. B. | Fully Sprinklered (All required areas are sprinklered) Partially Sprinklered (Notal Irequired areas are sprinklered) |
| Admin: Herschel Sedoris | ა | | | | | O. Š | C. None (No sprinkler system) |
| 3. SURVEY FOR MEDICARE | MEDICAID K4 | 4. DATE OF SURVEY 12/27/16 | MG PA | DATE OF PLAN APPROVAL 8/15/1975 | APPROVAL SURVEY UNDER 5. 2012 EXISTING K7 | | 6. 🔲 2012 NEW |
| 5. SURVEY FOR CERTIFICATION OF 1. HOSPITAL 2. | TION OF 2. KILLED/NURSING FACILITY | 4G FACILITY | 4. 🗌 ICF/IID UNDER HEALTH CARE | HEALTH CAF | RE 5. HOSPICE | | |
| IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW 1. WENTIRE FACILITY 2. DISTINCT PART OF (SPECIFY) | CHECK APPROPRIJ | ATE ITEM(S) BELO | A.V. | | 3. IFDISTINCTPARTO | IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? 3. \(\text{ YES} \) b. \(\text{ NO} \) | TAL ACCREDITED? |
| 6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY 105 | b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE | PITAL BEDS c. EDICARE 0 | . NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE | 105 | d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 105 | | e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID 0 |
| 7. A. W THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK | HE STANDARD, BA | SED UPON (CHECK | K ALL APPROPRIATE BOXES) | (S3 | | | |
| 1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ▼ B ☐ THE FACILITY DOES NOT MEET THE STANDARD | TH ALL PROVISIONS | : 2. ▼ ACCEPTAN | NCE OF A PLAN OF CORRE | CTION 3. | 1. COMPLIANCE WITH ALL PROVISIONS 2. M ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. CRESS 5. PERFORMANCE BASED DESIGN THE FACILITY DOES NOT MEET THE STANDARD | FSES 5. PEF | RFORMANCE BASED DESIGN |
| , , ,,,, | | TITLE | | OFFICE | | DATE | |
| SURVEYOR ID 21761 | | Fire Marshal | hal | State | State Fire Marshal's Office | 12/28/16 | 8/16 |
| FIRE AUTHORITY OFFICIAL Signature) TITLE Fire Marshal Super | ature) | TITLE Fire | Marshal Supervisor | OFFICE | SFMO | DATE | 12/29/16 |
| CMS FORMS SHALL BE COMPLE | TED AND RETAINED | D AS PART OF THE | = SURVEY RECORD. | - | | | |

Form CMS-2786R (10/2016)

W-0001-002

Form Approved OMB Exempt

| FIRE SAFETY SURVEY REPORT 2012 CODE | ORT 2012 CODE – HEALTH CARE | | 1. (A) PROVIDER NUMBER | 1. (B) MEDICAID I.D. NO. |
|---|---|--|--|---|
| Medicar | Medicare – Medicaid | 7.7 | 49-5141 | 49-51417 |
| OPTIONAL — Ch | PART I — Life ? PART II — Health Ca PART III — PART III — PART IIII — PART III — Safety I | PART I — Life Safety Code, New and Existing III — Health Care Facilities Code, New and Ey PART III — Recommendation for Waiver PART IV — Crucial Data Extract A - Fire Safety Evaluation System for Health C | PART I — Life Safety Code, New and Existing II — Health Care Facilities Code, New and Existing PART III — Recommendation for Waiver PART IV — Crucial Data Extract A - Fire Safety Evaluation System for Health Care Occupancies — CMS-2786T | es – CMS-2786T |
| Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change | cable records. Enter changes, if any, | alongside each it | em, giving date of change. | |
| 2. NAME OF FACILITY Alleghany Health & Rehab | 2. (A) MULTIPLE CONSTRUCTION (BLDGS) A. BUILDING 02 02 | | 2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 1725 Main Street | 4 (|
| Pharmacy Room Admin: Herschel Sedoris | B. WING C. FLOOR | Clifton Fo | Clifton Forge, VA 24422 | B. Partially Sprinklered (Not all required areas are sprinklered) C. None (No sprinkler system) |
| 3 SURVEY FOR | K3 4. DATE OF SURVEY | DATE OF PI AN APPROVAL | APPROVAL SURVEY UNDER | K0180 |
| MEDICARE MEDICAID | 12/27/16 | 4/2013 | | cisting 6. 🔲 2012 NEW |
| 5. SURVEY FOR CERTIFICATION OF | | | | |
| 1. HOSPITAL 2. KILLED/NURSING FACILITY | | 4. 🔲 ICF/IID UNDER HEALTH CARE | ARE 5. HOSPICE | |
| IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW | OPRIATE ITEM(S) BELOW | A CONTRACTOR OF THE PROPERTY O | 3. T IF DISTINCT PART OF | IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? |
| 1. BINTING TOWN TOWN STROME TOWN TOWN TOWN TOWN TOWN INSIDE THE Main bldg | ART OF (SPECIFY) One room inside | the Main bldg | a. TYES b. | ON [|
| 6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY CERTIFIED FC | b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE CERTIFIED FOR MEDICARE. | LED BEDS 0 | d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID | e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID 0 |
| 7. A. THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES) | D, BASED UPON (CHECK ALL APPROPRIA" | re Boxes) | | |
| 1. 🗌 COMPLIANCE WITH ALL PROVIS | 1. COMPLIANCE WITH ALL PROVISIONS 2. ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. C FSES 5. | CORRECTION 3. | RECOMMENDED WAIVERS 4 . [|] FSES 5. PERFORMANCE BASED DESIGN |
| $B. \hfill \square$ THE FACILITY DOES NOT MEET THE STANDARD $_{\rm K9}$ | STANDARD | | | |
| SURVEYOR (Signature) | TITLE | OFFICE | | DATE |
| SURVEYOR ID 21761 | Fire Marshal | Sta | State Fire Marshal's Office | 12/28/16 |
| FIRE AUTHORITY OFFICIAL (Signature) | TITLE Fire Marshal Supervisor | Visor OFFICE | SFMO | DATE 12/29/16 |
| CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD. | AINED AS PART OF THE SURVEY RECORI | D. | | |

PART IV - FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS 2786 FORMS)

W-0001-002

| Provider Number | Facility Name | | | Survey | Date | |
|--------------------------------|---------------------|---|---|---|---|-------------------------------|
| 49-5141 | Alleghany Health 8 | k Rehab - F | ⊃harmacy | Rm 12 | 2/27/16 | |
| K1 | | | | *K4 | *************************************** | |
| K6 DATE OF PLAN APPROVAL | K3 MULTIPLE COI | | | D | JILDING | <u></u> |
| | TOTAL NUMBER OF E | BUILDINGS . | 02 | □ B. W | | |
| 4/2013 | NUMBER OF THIS BU | III DING (| 02 | | LOOR PARTMENT | LINIT |
| LSC FORM INDICATOR | NOWIDER OF THIS BO | | | | | UNDER CHAPTER 33, |
| | | | EXISTING | | OOKVETED | ONDER OTAL TER 35, |
| | CARE FORM | | SMALL | (16 BEDS (| OR LESS) | |
| 12 2786R | 2012 EXISTING | | 0.00 | 1 | PROMPT | |
| 13 2786R | 2012 NEW | | К8 | 2. | SLOW | |
| AHC | O FORM | | LARGE | | | |
| 14 2786U | 2012 EXISTING | | | | | |
| 15 2786U | 2012 NEW | | 140 | 4. 5. | PROMPT SLOW | |
| | | | K8 | 6. | IMPRACT | TICAL |
| ICF/II | D FORM | | APARTME | ENT HOUSE | | |
| 16 2786V, W, X | 2012 EXISTING | | / II / II (I I I I I I I I I I I I I I | | PROMPT | |
| 17 2786V, W, X | 2012 NEW | | K8 | 8. | | |
| L | | | | <u></u> 9. | IMPRACT | ΓICAL |
| *K7 T2 SELECT NUMB | ER OF FORM USED FRO | | | | | |
| GLLEGT NOWID | ER OF FORW OSED FRO | JIVI ADOVL | | | | |
| (Check if K321 or K351 ar | | le | COMPLETI EXISTING | E IF ICF/IID IS | SURVEYED | UNDER CHAPTER 33, |
| in the 2786 M, R, T, U, V, | W, X, and Y.) | | ENTER E | - SCORE | | |
| K321: | K351: | | K5: | | e.g. 2.5 | |
| | | | No. | | e.g. 2.5 | |
| *K9 FACILITY MEETS | LSC BASED ON (Check | all that App | ly) | | | |
| A1. | A2. | A3 | 3. | A4. | | A5. |
| (COMP. WITH ALL PROVISIONS) | (ACCEPTABLE P | OC) | (WAIVERS) | (F: | SES) | (PERFORMANCE BASED DESIGN) |
| FACILITY DOES NOT ME | ET LSC K0180 | | | | | |
| | _ | A. 🚺 | | В. | | C |
| В | (All re | SPRINKLEF equired areas ar sprinklered) | | TIALLY SPRI Not all required a sprinklere | areas are | NONE (No sprinkler system) |
| *MANDATORY | | - ', | | | - | |

PART IV - FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS 2786 FORMS)

W-0001-001

| Prov | vider N | lumber | Facility Name | | VI | Survey Date |
|-----------|---------|---------------------------|-----------------|---|----------------------|--|
| 124 | 49-51 | 41 | Alleghany H | Health & Rehab | | 12/27/16 |
| <u>K1</u> | | | | | | *K4 |
| K6 | | OF PLAN ROVAL | | IPLE CONSTRUCTION | A | A. BUILDING |
| 0/45 | | | TOTAL NUME | BER OF BUILDINGS | | B. WING C. FLOOR |
| 0/10 | 5/197 |) | NUMBER OF | THIS BUILDING | 01 | D. APARTMENT UNIT |
| LSC | FORI | M INDICATOR | | | | ICF/IID IS SURVEYED UNDER CHAPTER 33, |
| | | HEALTH | CARE FORM | | EXISTING | |
| | 12 | 2786R | 2012 EXISTING | G | SMALL (1 | 6 BEDS OR LESS) |
| | 13 | 2786R | 2012 NEW | | К8 | 1. PROMPT 2. SLOW 3. IMPRACTICAL |
| | | AHC | O FORM | | LARGE | 3. IMPRACTICAL |
| | 14 | 2786U | 2012 EXISTING | G | LAROL | |
| | 15 | 2786U | 2012 NEW | | К8 | 4. PROMPT 5. SLOW |
| | | ICE/II | DFORM | | | 6. IMPRACTICAL |
| | 16 | | 2012 EXISTING | | APARTMENT | HOUSE |
| | 17 | 2786V, W, X | | | К8 | 7. PROMPT 8. SLOW 9. IMPRACTICAL |
| *K7 | 12 S | SELECT NUMB | ER OF FORM U | SED FROM ABOVE | | J. INITIVACTIONE |
| | | | e marked as not | applicable | COMPLETE IF EXISTING | ICF/IID IS SURVEYED UNDER CHAPTER 33, |
| in th | e 2786 | 6 M, R, T, U, V, | W, X, and Y.) | | ENTER E - S | CORE |
| | | K321: | K351: | | K5: | e.g. 2.5 |
| *K9 | FA | CILITY MEETS | LSC BASED O | N (Check all that App | ily) | |
| | A | I | A2. | A | 3. | A4. A5. |
| | | MP. WITH ALL OVISIONS) | (ACCEP | TABLE POC) | (WAIVERS) | (FSES) (PERFORMANCE BASED DESIGN) |
| FAC | ILITY | DOES NOT ME | ET LSC | K0180 | | |
| 41.4.4 | · | В. | | A. FULLY SPRINKLEI (All required areas a sprinklered) | | C |
| *MA | NDAT | ORY | | | | |